Health Insurance

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Introduction
Andrew McPhail

The private health insurance industry is an integral part of the Australian health care system and provides hospital treatment insurance coverage for 44.6 per cent of the Australian population. This is the highest level of coverage since the introduction of Life Time Health Cover in 2000/2001.

There are currently 35 private health insurers registered in Australia. Among this total are 10 for-profit insurers accounting for 70.4% of total market share at 30 June 2010.

Whilst there has been minimal consolidation in the industry in the past 12 months there have been acquisition attempts made and fund mergers have occurred resulting from acquisitions made in recent years. As the economic environment becomes more settled the prospect of further industry consolidation remains very real.

The market for private health insurance in Australia remains very competitive with insurers competing for new members and to attract members of other insurers. The competition by insurers to attract younger members is intense, particularly in light of the ever increasing volume and cost of claims in recent times.

Insurers also seek to attract members through quality service, brand loyalty and broader value recognition of the private health insurance product.

Government policy continues to play a significant role in shaping private health insurance in Australia. Government policies affect industry demand by influencing the cost of private health insurance to the policyholder via the mandated approval of rate rises and the tax rules.

In light of the change in the balance of power in the Senate from 1 July 2011 the industry is closely monitoring the ongoing government debate surrounding the following areas:

- *proposed means testing of the private health insurance rebate;*
- *proposed increases to the Medicare levy surcharge for those who do not purchase private cover;*
- *the National Health and Hospitals Reform Commission report; and*
- *the National Health and Hospitals Network.*

Despite the continued challenging environment in which Government policy continues to play a significant role the outlook for the private health insurance industry remains positive.

4.1

Statistics

	Ranking Measure:					Performance:					
	Contributions					Membership		Other revenue		Result after tax	
Entity	Current $m	Prior $m	Current Rank	Prior Rank	% Change	Current '000	Prior '000	Current $m	Prior $m	Current $m	Prior $m
1 Medibank Private Ltd (including AHMG)	4,268	3,959	1	1	8%	1,738	1,703	161	(26)	300	104
2 BUPA Australia Health Pty Ltd (Including MBF)	4,050	3,781	2	2	7%	1,503	1,473	133	115	237	174
3 HCF (including MUA)	1,526	1,421	3	3	7%	571	557	57	(3)	75	27
4 HBF	933	854	4	4	9%	424	413	72	(129)	98	(115)
5 NIB	901	829	5	5	9%	407	384	31	19	55	43
6 Australian Unity Health Ltd	423	459	6	6	-8%	168	180	14	(4)	32	14
7 Teachers Federation Health	299	265	7	7	13%	98	94	12	4	25	10
8 Defence Health Ltd	224	201	8	8	11%	85	80	12	(3)	22	6
9 GMHBA Ltd	217	191	9	9	14%	91	86	7	3	6	8
10 CBHS Health Fund Ltd	205	180	10	10	14%	70	67	6	3	10	9
11 Westfund Ltd	102	90	11	11	13%	44	41	7	1	7	3
12 Health Partners	96	87	12	12	10%	36	35	7	(1)	8	(2)
13 Latrobe Health Services Inc	91	78	13	13	17%	38	35	5	7	8	11
14 Queensland Teachers' Union Health Fund Ltd	82	75	14	14	9%	23	22	2	1	6	3
15 Healthguard Health Benefits Fund	79	72	15	15	10%	27	27	7	-12	15	-7

Source: The statistics are in respect of registered health benefit organisations as reported in the PHIAC annual statistics as at 30 June 2010 and 30 June 2009.

Notes: Membership is based on the number of policies in force.

Other revenue comprises mainly of investment income.

Benefits ratio is benefits paid as a proportion of contributions.

Where there are more than one entity within the group, a weighted average based on net assets is used to estimate the overall solvency ratio, and a weighted average based on contributions is used to estimate overall net margin.

Financial Position:								Ratios:					
Outstanding claims		Investment securities		Net assets		Total assets		Solvency		Benefits		Net margin	
Current $m	Prior $m	Current $m	Prior $m	Current $m	Prior $m	Current $m	Prior $m	Current %	Prior %	Current %	Prior %	Current %	Prior %
397	476	2,063	1,779	1,925	1,642	3,060	2,714	3.02	2.45	85%	86%	3.8%	3.3%
499	489	1,405	1,287	978	1,024	1,685	1,841	2.97	3.29	83%	85%	5.7%	2.6%
118	119	559	473	714	641	1,105	1,001	3.11	2.11	88%	86%	3.2%	2.2%
87	75	596	484	494	396	796	674	3.17	2.77	88%	88%	2.8%	1.7%
62	56	187	164	226	205	424	380	2.98	2.79	83%	83%	5.2%	4.8%
37	41	76	91	84	98	242	268	2.35	2.21	82%	83%	8.1%	8.0%
33	29	183	153	143	118	217	183	6.68	6.95	86%	88%	4.5%	2.3%
28	24	174	147	138	114	196	166	9.32	8.88	88%	88%	5.6%	4.5%
17	15	142	130	97	91	165	153	6.15	6.64	90%	88%	-0.3%	2.5%
20	16	109	93	86	75	123	107	9.08	8.55	91%	90%	2.0%	3.1%
8	7	89	77	73	65	100	87	7.44	8.10	88%	86%	0.4%	1.8%
5	6	54	46	57	49	72	65	6.87	5.86	91%	93%	0.6%	-2.3%
8	7	111	99	102	94	124	113	9.50	10.26	87%	85%	3.0%	5.0%
7	6	42	35	62	56	78	70	7.39	6.45	85%	85%	5.4%	2.9%
8	8	65	50	58	43	79	63	8.11	5.57	80%	82%	10.1%	7.8%

4.2

Key developments in 2010/11

Participation rates in the private health insurance industry continue to grow with the take up of private health insurance more than keeping pace with the overall growth in the population. Premium revenue increased by 8.4% from 2008/09 to 2009/10 whilst at the same time benefits paid increased by 7.7%. Overall, the industry recorded a profit after tax of $953 million for 2009/10 compared with $324 million for 2008/09.

Key development	Overview
Annual premium rate increase approved by government	The Minister for Health and Ageing approved an increase in private health insurance premiums by an average of 5.57% effective 1 April 2011 (2010: 5.78%) which is lower than the 2010 customer prince index increase in hospital and medical services of 6%.
The Disclosure Standard – newest of the prudential standards issued by PHIAC commenced from 1 January 2011	The Disclosure Standard is set out in Schedule 3 of the Private Health Insurance (Insurer Obligations) Amendment Rules 2010 (No. 1) which amend the Private Health Insurance (Insurer Obligation) Rules 2009. The Disclosure standard requires insurers to provide information to PHIAC, which will facilitate the ongoing risk assessment of insurers and early detection of prudential issues. PHIAC continues to work on a range of prudential standards.
Medicare Levy Surcharge increase – 1 July 2010	For the 2010/11 taxation year the Medicare Levy Surcharge (MLS) threshold for singles is $77,000 (2009/10 $73,000) and for couples and families, the threshold is $154,000 (2009/10 $146,000).
Number of registered health insurers reduced from 37 to 35	In the last year the health insurance industry has seen minimal movement amongst its key players. The only consolidation in the industry was the 1 July 2010 mergers by BUPA of all policies into one registered health insurer as opposed to three. This merger decreased the number of private health insurers operating in Australia from 37 to 35.

As a heavily regulated industry, the Private Health insurance industry continues to be shaped by federal government health policy. The federal government has a significant reform agenda for health and while these reforms are in the development phase, the government is seeking to make changes to rates which may well impact private health insurance business. Some of these proposals are summarised below.

Topic – Emerging issues	*Summary of development / nature of impact*
Proposed changes to the Medicare Levy Surcharge	In the 2009-10 Budget, the Government put forward a proposal to increase the Medicare Levy Surcharge (MLS) rates for higher income earners but was unable to win Senate approval. There is currently a proposal before Parliament to increase the MLS in tiers, as per the health insurance rebate tiers. For example: • For income between \$75,001 – \$90,000, the MLS will remain at 1% • For income between \$90,001 = \$120,000, the MLS will increase to 1.25% (from 1%) • For income over \$120,001, the MLS will increase to 1.5% (from 1%) There is a similar proposal being considered for couples and families.
Government pushing to means test the 30% private health insurance rebate	After failing to secure a full means test of the private health insurance rebate the Government is currently considering a watered down means test proposal whereby singles earning more than \$75,000 and families earning more than \$150,000 would have their tax rebate for health insurance cut from 30 to 20%. Singles earning more than \$90,000 and families earning more than \$180,000 would have their rebate cut from 30 to 10%.
IFRS for Insurance Contracts – Exposure Draft	The Private Health insurance industry has made submissions to the International Accounting Standards Board (IASB) with respect to the Insurance Contracts Exposure Draft due to its implication that health insurance contracts would move from being short duration to being long duration contracts due to the definition of the contract boundary. This issue and others arising due to the exposure draft are discussed in detail in Chapter 1 of this publication.

4.3

Regulation and supervision

Private Health Insurance Administration Council (PHIAC)

The private health insurance industry is regulated by the Australian Government Department of Health and Ageing (DoHA) in conjunction with its private health insurance portfolio agency the PHIAC. The DoHA sets down private health insurance policy in addition to fulfilling other functions such as managing the annual rate review process.

PHIAC is an independent statutory authority which was established as a body corporate under section 82B of the *National Health Act 1953* in 1989. PHIAC continues in existence by force of section 264-1 of the *Private Health Insurance Act 2007* (the Act) which came into effect from 1 April 2007.

Section 264-5 of the Act sets out PHIAC's broad objectives which are to:

- foster an efficient and competitive health insurance industry;
- protect the interests of consumers; and
- ensure the prudential safety of individual private health insurers.

PHIAC monitors and regulates the private health insurance industry and the provision of private health insurance related information to the Government and other stakeholders.

PHIAC's functions are:

- to administer the registration of private health insurers;
- to administer the Risk Equalisation Trust Fund;
- to oversee information collection, compliance, enforcement, public information, agency cooperation; and
- to advise the Minister about the financial operations and affairs of private health insurers.

PHIAC supervisory objectives are met in the following ways:

- reviewing compliance with solvency and capital adequacy standards;
- examining from time to time the financial affairs of the private health insurers and conducting site visits of insurers;
- reviewing the value of assets and liabilities of each health benefit fund by carrying out independent actuarial assessments;

- the collection and review of audited financial and other returns so that PHIAC can monitor the financial position of individual private health insurers and its ability to meet their outstanding claims as they fall due; and
- the collection of signed statements and declarations from the private health insurers and their approved auditors that provide PHIAC with assurance that systems and procedures to meet regulatory requirements are in place, are adequate and have been independently tested.

As at 1 July 2010 PHIAC was supervising 35 private health insurers operating in Australia, which provide private hospital treatment insurance coverage for 44.6 per cent of the Australian population. Of these 35 insurers 13 were restricted access and 22 were open access insurers, with 10 operating on a for-profit basis.

The market share of the for-profit insurers increased from 42.3% at 30 June 2009 to 70.4% at 30 June 2010, mainly driven by the conversion of Medibank Private Limited to for-profit from 1 October 2009.

PHIAC and the Australian Prudential Regulation Authority (APRA)

PHIAC and the Australian Prudential Regulation Authority (APRA) have a memorandum of understanding (MOU) setting out a framework for co-operation in areas of common interest. The MOU recognises the importance of close co-ordination and co-operation between the two organisations. An updated MOU came into effect on the 6 January 2011. In particular, the refreshed document focuses more on information sharing and policy development and is designed to facilitate a uniform regulatory approach.

Authorisation

PHIAC has the power, on application, to register as private health insurers, bodies that are registered bodies for the purposes of the *Corporations Act 2001*. PHIAC will take into account the ability of the applicant to comply with the obligations imposed by the Act. Registration is granted by PHIAC subject to terms and conditions as it sees fit.

Private health insurers must gain approval from the Minister for Health and Ageing for any fund rule changes, including rate changes.

Appointed Actuaries

All private health insurers are required to have an actuary appointed by the insurer. Under section 160-30 of the Act the appointed actuary is obliged to report both to the insurer and PHIAC. Schedule 2 of the *Private Health Insurance (Insurers Obligations) Rules 2009* specifies the duties of the appointed actuary and defines the notifiable circumstances of which private health insurers are obliged to keep the appointed actuary informed.

Community rating principle and risk equalisation

Private health insurers do not typically carry reinsurance. However, private health insurers participate in the risk equalisation arrangements administered by the PHIAC.

The principle of community rating prevents private health insurers from discriminating between people on the basis of their health status, age, race, sex, sexuality, the frequency that a person needs treatment, or claims history. The risk equalisation arrangements scheme supports the principle of community rating as it averages the cost of hospital treatment across the industry. The scheme transfers money from private health insurers with younger healthier members with lower average benefits payments to those private health insurers with an older and less healthy membership profiles and which therefore have higher average benefits payments. This redistributes the burden of high cost claims across the industry to avoid the financial strain of the costs being borne by individual private health insurers.

The redistribution is calculated based on the average benefit paid by Australian private health insurers (per state) to customers in their aged-based pool (over 55 years old) and the high costs claimants pool (claims exceeding $50,000 each). The arrangement operates by private health insurers paying / receiving a levy into / from the Health Benefits Risk Equalisation Trust Fund. Private health insurers prepare and submit membership and benefit data to PHIAC on a quarterly basis through the PHIAC 1 returns. Effectively, a health insurer that paid more risk equalised benefits than the state average will have an amount receivable from the Risk Equalisation Trust Fund, whereas a health insurer that paid less will have an amount payable to Risk Equalisation Trust Fund.

Medicare Levy Surcharge (MLS)

The MLS is levied on Australian taxpayers who do not have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system. The surcharge is calculated at the rate of 1% of taxable income. When the Federal Government amended the MLS thresholds in 2008, they also required that they be indexed annually to Average Weekly Earnings. That means that every year on 1 July, a revised threshold level will take effect in line with that index.

4.4

Solvency and capital adequacy

Authorised health insurers are subject to solvency and capital adequacy requirements under Schedule 2 and 3 respectively of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*. These requirements were legislated under Divisions 140 and 143 of the Act.

PHIAC has been undertaking a review of the capital adequacy and solvency standards since their issue in 2007. A date for implementation of the revised standards is not yet known as PHIAC are still to conclude following consultation and comment from stakeholders.

The standards place rigorous reporting requirement on funds. They need to demonstrate the soundness of their financial position, considering both their existing balance sheet position and the profitability of future business.

The Act specifies a two-tier capital requirement for health insurers, with each tier considering the capital requirements of a different set of circumstances.

The *Solvency Standard* is a short-term test that prescribes the minimum capital requirements of a health insurer to ensure that under a wide range of circumstances it would be in a position to meet its obligations to members and creditors. The solvency standard is to ensure, as far as practicable, that at any time the financial position of the health benefits fund conducted by a private health insurer is such that the insurer will be able, out of the fund's assets, to meet all liabilities that are referable to a fund as those liabilities become due.

The solvency standard is essentially based on a "run-off" view of the fund. The health insurer must demonstrate that it can reliably meet its accrued liabilities and obligations in the event of a wind-up. It should be noted that there is a difference between meeting the solvency standard and being solvent in terms of the *Corporations Act 2001*. A fund meeting the solvency standard is required to hold reserves to meet its obligations to members and staff, such that it should be in a position to avoid insolvency as defined under the *Corporations Act 2001*.

The *Capital Adequacy Standard* is a medium-term test that prescribes the capital requirement of a health insurer to ensure that its obligations to, and reasonable expectations of, contributors and creditors can be met under a range of adverse circumstances. The capital adequacy requirement is thus based on an ongoing view that requires a fund to show that it has sufficient capital to implement its business plans, accept new business, absorb short-term adverse events from time to time and remain solvent.

The solvency and capital adequacy standards are based on the concepts of liability risk, asset risk and other risks.

Liability risk

The liability risk requirement can be considered as the amount required to meet existing liabilities (solvency and capital adequacy standard) plus an amount to meet the liability associated with continuing to write business (capital adequacy standard). The amount required to meet existing liabilities is set as the sum of the:

- Net claims liability;
- Risk equalisation accrued liability; and
- Other liabilities.

The net claims liability is outstanding claims net of risk equalisation on outstanding claims and the liability in respect of unexpired risk (determined as the premiums paid in advance multiplied by a specified loss ratio). Each item includes a margin and includes associated claims handling expenses. The margin is prescribed at 10 per cent for the solvency calculation, while the capital adequacy margin is determined by the board of directors of each private health insurer (subject to a prescribed minimum of 12.5 per cent) based on a qualitative risk assessment of the health insurer's membership base and the volatility of claims. For both the solvency and capital adequacy standards, the net claims liability should not be less than the reported liability.

The risk equalisation accrued liability is the amount due/payable from the risk equalisation trust fund in the coming period in respect of members covered and benefits paid from prior periods. The liability is thus the risk equalisation levy for members covered in the preceding quarter, less benefit payments that can be recovered from the risk equalisation trust fund. A margin is added to the risk equalisation levy (currently 10 per cent).

The capital adequacy standard is also concerned with the additional capital required to continue to cover members' future benefits (referred to as the renewal options reserve) and to fund business plans (referred to as the business funding reserve).

The renewal options reserve takes into account the risks and potential costs associated with providing members with the right to renew membership. The reserve is based on a best-estimate projection of the net earned contribution income less incurred payments and costs, with suitable conservative margins added to the cash outflows in the projection.

The business funding reserve is intended to ensure capital adequacy over the projected period. It requires an insurer to hold sufficient reserves to meet the demands of any planned increase in membership and of other business development strategies.

Asset risk

The asset risk is the risk to the value of assets supporting the liabilities. The asset risk requirement can be considered in two parts:

- Inadmissible assets; and
- Resilience reserve.

Inadmissible assets include assets in associated entities and risks from asset contagion, asset concentration and general asset credit or liquidity.

The factors considered in calculating the inadmissible asset reserve are as follows:

- a reserve must be maintained if the value of a business' assets in a run-off situation is less than the value of the assets in an ongoing situation;
- if the health insurer has investments in an associate or subsidiary that is prudentially regulated, a reserve must be maintained that represents the prudentially regulated capital within the value of the associate or subsidiary in the financial statements of the health insurer; and
- a reserve is required to be held against the adverse impact of concentration of investments in a particular asset with a particular counterparty or related party.

The capital adequacy standard prescribes certain limits and weightings depending on the asset type. The resilience reserve is based on an assessment of the health insurer's ability to sustain shocks that are likely to result in adverse movements in the value of its assets relative to its liabilities. The reserve is calculated with reference to the admissible assets of the health insurer and by applying a calculated diversification factor (based on each health insurer's asset exposure) to a prescribed movement in returns per investment class.

The resilience reserve is intended to provide protection against adverse movement in the value of assets. The reserve considers the fall in value of assets by the investment sector under adverse conditions, assuming greater adversity in the capital adequacy test. An offset is allowed for diversification of assets.

Other risks

The standards also require an allowance for management capital and, in the solvency test, for an expense reserve. The management capital reserve is designed to ensure that private health insurers maintain a minimum dollar level of capital. In practice, this test applies only to small private health insurers. The expense reserve, in the run-off test, allows for unavoidable expenses expected to be incurred as a health insurer adjusts to a run-off status. The solvency standard calculates the expense reserve as 40 per cent of total non-claim expenses.

Investment Policy

There is no restriction on investments that may be held by health insurers. However, in calculating the solvency requirement and the capital adequacy requirement under the respective standards, the level of capital required varies with the risk profile of the investment portfolio. This is addressed through the calculation of an inadmissible assets reserve and a resilience reserve.

4.5 Governance and assurance

Since 2007, PHIAC has had the authority to issue prudential standards compliance with which is mandatory for all private health insurers.

Current prudential standards on issue are:

- the Capital Adequacy standard
- the Solvency standard
- the Appointed Actuary standard
- the Governance standard
- the Disclosure standard

For further discussion of the Capital Adequacy and Solvency standards refer to section 4.4.

The Appointed Actuary standard is set out in Schedule 2 of the Private Health Insurance (Insurer Obligations) Rules 2009. The standard articulates the requirements of an appointed actuary of a private health insurer and commenced on the 31 March 2007.

The Disclosure standard is set out in Schedule 3 of the Private Health Insurance (Insurer Obligations) Amendment Rules 2010 (No. 1) which amend the Private Health Insurance (Insurer Obligation) Rules 2009. The Disclosure standard requires insurers to provide information to Council, which will facilitate the ongoing risk assessment of insurers and early detection of prudential issues. This is the newest of the prudential standards and commenced from 1 January 2011.

The Governance standard is set out in Schedule 1 of the Private Health Insurance (Insurer Obligations) Rules 2009 and commenced on 1 January 2010. PHIAC's objectives in relation to governance are to ensure that insurers are managed in a sound and prudent manner by a competent board of directors which is capable of making reasonable and impartial business judgements in the best interest of the insurer and which gives due consideration to the impact of its decisions on policyholders.

4.6

Financial and regulatory reporting

Private health insurers are required to prepare financial statements that comply with Australian Accounting Standards, in particular AASB 1023 *General Insurance Contracts* ("AASB 1023"). The key principles and disclosure requirements of AASB 1023 are set out in the General Insurance section of this publication.

The International Accounting Standards Board (IASB) released the long awaited exposure draft on Insurance Contract accounting on 30 July 2010 following extensive preparation with the US Financial Accounting Standards Board (FASB). The proposal in the exposure draft is for a comprehensive standard to address recognition, measurement, presentation and disclosure for insurance contracts. Refer to Chapter 1 for further details.

Australian Health Insurance Association guidance notes

In order to ensure a consistent approach by private health insurers in interpreting the requirements of AASB 1023, the Australian Health Insurance Association (AHIA) has developed guidance notes to assist private health insurers in applying AASB 1023.

The key issues addressed by the AHIA guidance notes are summarised below.

Premium revenue

Under AASB 1023, premium revenue is recognised from the date on which the insurer accepts insurance risk ("attachment date") over the period of the contract in accordance with the pattern of the incidence of risk expected.

Unlike most other forms of insurance contract, a health insurance contract does not typically stipulate a fixed period of cover as contracts typically require payment in advance and include an option for the policyholder to renew. In practice, private health insurers recognise premiums from the date cash is received over the period covered by the payment. It should be noted that under AASB 1023, private health insurers are legally obliged to continue cover (but not pay benefits for the period in arrears) for 63 days if a policyholder's premiums are in arrears. Private health insurers will therefore need to consider past experience to determine whether it is appropriate to accrue for premiums in arrears.

Measurement of outstanding claims

Matters of particular importance to private health insurers are set out below.

Central estimates

A central estimate of claims incurred is the mean of all possible values of outstanding claims liabilities as at the reporting date. The central estimate, therefore, has a 50 per cent probability of adequacy (i.e. there is a 50 per cent chance that the central estimate will be adequate to meet all future claims payments).

Risk margin

AASB 1023 requires that the outstanding claims liability includes a risk margin to reflect the inherent uncertainty in the central estimate of the present value of the expected future payments. It does not specifically prescribe a fixed risk margin or probability of adequacy. The risk margin for a given level of probability of adequacy will be specific to each insurer, taking into account the variability of claims processing, the availability of claims data and the features of the claims being provided for at the reporting date.

Discounting

AASB 1023 requires the liability for outstanding claims to be discounted to reflect the time value of money. As health insurance claims are generally settled within one year, private health insurers may be able to demonstrate that no discounting of claims is required as the difference between the future and present value of claims payments is not material.

Deferred acquisition costs

When acquisition costs meet certain criteria they must be deferred, recognised as assets and amortised systematically. Private health insurers need to establish procedures to identify relevant costs to be deferred.

Unearned premium liability

Typically private health insurers have referred to the unearned premium liability as “contributions in advance”. These are determined in accordance with AASB 1023.

Liability adequacy test

AASB 1023 requires a liability adequacy test to be performed by the private health insurer at the level of a portfolio of contracts that are subject to broadly similar risks and are managed together as a single portfolio. The AHIA guidance note suggests that private health insurers should dissect portfolios into at least two classes of business: hospital and ancillary. A private health insurer may determine further disaggregation of portfolios depending on its particular portfolio of products. The liability adequacy test typically incorporates an analysis based on the unearned premiums at reporting date and the constructive obligation in relation to projected premiums up to the subsequent 1 April rate review.

Annual accounts

Audited annual *Corporations Act* financial statements must be lodged with ASIC in line with the requirements of the *Corporations Act*, i.e. within three months for a disclosing entity and four months for a non-disclosing entity. Private health insurers are required to lodge annual audited financial statements with PHIAC on, or just after, 30 September each year.

Other returns

All private health insurers must provide a number of other returns under various legislative requirements. These include:

PHIAC 1 Returns – Quarterly state and territory-based returns must be prepared for all states under the Private Health Insurance Act 2007. The returns must be prepared in accordance with the guidelines established in PHIAC circulars and contain granular data on each health insurer's membership and benefit payment composition. Each quarterly return is audited by the health insurer's external auditor at the end of the financial year.

PHIAC 2 Returns – This is the main reporting requirement under the solvency and capital adequacy standards. Quarterly unaudited returns are lodged with PHIAC and the annual return is audited by the health insurer's external auditor. The annual return includes an unaudited certification by directors in relation to the capital adequacy margin, loss ratio and risk management procedures.

PHIAC 3 Returns – These quarterly returns contain prostheses reports and are not required to be audited.

PHIAC 4 Returns – Specialty gap cover data is required to be provided quarterly to PHIAC. The totals reported on this quarterly PHIAC 4 medical gap report should be consistent with data reported in the quarterly PHIAC 1 return. The returns are not required to be audited.

Rebate Returns – Private health insurers are required to lodge a monthly application on or before the seventh day of the following month for the rebate with the Medicare Australia CEO in line with the requirements of the Private Health Insurance Act 2007 in order to receive the rebate. Under subsection 279-50(6) Medicare Australia may require a health fund to give Medicare Australia an Auditor's Certificate regarding the health insurer's participation in the Premium Reduction Scheme.

Second Tier Benefits Returns – The Private Health Insurance Benefit Requirement Rules are amended regularly by the Department of Health and Ageing. Under schedule 5 of these requirements, if a health facility is accredited with a Commonwealth provider number and it does not have Hospital Purchaser Provider Agreements (HPPA) or a similar agreement with a particular health insurer, it may approach the health insurer for its second tier benefits rates. The private health insurers are required to calculate 85 per cent of the average HPPA rates, effective at 1 August, for procedures that are included in the majority of their HPPAs. The audited second tier benefits return must be lodged with both the Department of Health and Ageing and PHIAC by 30 September each year.

Key lodgement dates
Private Health Insurance Administration Council

- Unaudited Quarterly PHIAC 1, 2, 3 and 4 returns
  Within four weeks after the end of the quarter to which it relates.
- Annual audited quarterly PHIAC 1 returns
  All four quarters returns within 3 months of the end of the financial year, or such time as approved by the Commissioner.
- Annual audited PHIAC 2 return and a statement by the directors in relation to the capital adequacy margin, loss ratio and risk management procedures
  Within 3 months of the end of the financial year or such time as approved by the Commissioner.
- Annual audited financial statements of the health insurer
  On, or just after, 30 September each year.
- Unaudited financial condition report prepared by the insurer's appointed actuary
  On, or just after, 30 September each year.

Risk Equalisation Trust Fund

- Letters advising of the distributions to / from the fund are sent out quarterly following the processing of PHIAC 1 returns.
  Approximately eight weeks from each quarter end.

Annual levy

- Annual levy is based on health insurer membership numbers.
  Payment is due quarterly, within two weeks of the request for payment.

Medicare Australia

Lodgement of returns

- Audited annual statement regarding the health insurer's participation in the Federal Government's 30% Rebate on Private Health Insurance – Premium Reduction Scheme.
  Within 20 days from the end of the year (approximately).

Federal Department of Health and Ageing

- Un-audited Second Tier Default Benefit rates.
  By 31 August each year (where applicable).
- Audited Second Tier Default Benefits rates.
  By 30 September each year (where applicable).

4.7

Taxation of health insurers

An organisation which is a registered health benefits organisation for the purposes of the *Private Health Insurance Act 2007*, and which is not in business for the purposes of profit or gain for its individual members, is exempt from income tax. The fact that a health fund may offer rebates and/or discounts to members has not been construed as the distribution of profits or gains to members. Accordingly, the scope of this exemption will depend generally on the type of activities carried out by the organisation insofar as they do not disqualify it from registration under the Act. Registered health benefit organisations that operate for the purposes of profit or gain are taxed like normal corporates. Although Division 321of the Income Tax Assessment Act 1936 (taxation of general insurers) does not apply to health insurers, taxable health insurers generally apply broadly equivalent principles to Division 321.

Goods and Services Tax

Under the Australian GST legislation, some classes of insurance are treated differently, leading to different implications for insurers and insured parties.

In relation to Health Insurance, special provisions result in most forms of health insurance to be treated as GST free (known as "zero-rated supplies" in other jurisdictions). This means that health insurers are not required to account for GST on premium income derived from their businesses. In addition, special rules relate to the expenses incurred by GST-free Health Insurers such that they are only entitled to recover input tax credits on the expenses incurred running the business and managing claims. No entitlement to input tax credits will arise for expenses incurred in settling a claim under an insurance policy which is GST-free.

Where an insurance policy may be treated as either GST-free, taxable or input taxed, the GST-free treatment will prevail.

In relation to the investment activities of an insurance entity, it is important to consider if the Financial Acqusitions Threshold test in the GST law applies and if so whether or not the Threshold has been exceeded by the insurer due to the quantum of expenses incurred in relation to their investing activities.

Stamp duty

Health insurance policies are exempt from stamp duty in all Australian states and territories provided the policies are issued by an organisation registered under Part VI of the National Health Act 1953 or a "private health insurer" (as defined in the Private Health Insurance Act 2007 (Commonwealth) Schedule 1) for the Western Australian duty legislation).